DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the doors protecting the corridor openings. The findings include: 1. Observations on 6/27/11, at 10:30 AM, revealed the following doors did not latch within the door frames: a. Resident rooms 1, 103, 156, and 160 b. Corridor's fire door located next to room 136 c. Corridor's fire door located next to room 98	K 018	K 018 A. What corrective action(s) will be accomplished for those residents found to have been affected: 1), 2) Between 6/27/11 and 8/3/11 the Director of Environmental Services and Maintenance Assistant will adjust interior doors for proper latching and ensure doors are not sticking to door frame. By 8/3/11 Director of Environmental Services and Maintenance Assistant will adjust exterior fire doors to prevent sticking and ensure proper latching. 3) On 6/27/11 Director of Environmental Services and Maintenance Assistant moved beds in room 96 and 136 to prevent door closure obstruction. 4) Between 6/29/11 and 8/3/11, the Director of Environmental Services and Maintenance Assistant will adjust the lobby's fire/smoke door to close within the frame. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1), 2) By 7/21/11 the Executive Director will complete education with associates requesting that they turn in work orders to Maintenance for any doors that do not latch in frame or that stick in frame. 3) By 7/21/11 the Director of Enviromental Services and Director of Nursing will complete education with housekeeping and nursing associates requesting that they observe and move beds if obstructing door closure. 4) By 7/12/11 the Executive Director will complete education with Maintenance Assistant and Environmental Service Director to ensure that fire/smoke doors close completely in monthly fire drills.	8/3/2011 8/3/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 7/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 2. Observations on 6/27/11 at 10:30 AM, revealed the following doors were sticking to the door frames: a. Resident rooms 100, 102, 104, 115, 124, 127, 136, 149, 152 b. Exit doors located next to rooms 114 and 152 c. Employee's break room d. Fire door located in the D corridor next to employee's break room. e. Conference room 3. Observation of resident rooms 96 and 136 on 6/27/11 at 11:08 AM, revealed the resident beds were obstructing the closing of the doors. 4. Observation on 6/27/11 at 12:15 PM, revealed the lobby's fire door located next to the bathroom did not close within the door frame. These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 018	K 018 Continued C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? 1), 2) Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a weekly room-to-room audit for three months of doors in facility to ensure proper latching and absence of sticking. Corrections will be made as needed. 3) Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a weekly room-to-room audit of beds in facility to ensure they are not obstructing door closure. Corrections will be made as needed. 4) Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a weekly door-to-door audit for three months of fire/smoke doors in facility to ensure proper closure. Corrections will be made to doors as needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of weekly door latching, sticking, bed obstruction, and fire door closure audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011 8/3/2011
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	K 025 A. What corrective action(s) will be accomplished for those residents found to have been affected:	

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K 025	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the smoke barriers located in the attic. The findings include: 1. Observation on 6/27/11 at 9:45 AM, revealed penetrations in the smoke barrier located in the attic above room 117. 2. Observation on 6/27/11 at 9:47 AM, revealed the top of the smoke barrier located in the attic above room 117 was not sealed at the roof deck. 3. Observation on 6/27/11 at 10:07 AM, revealed the draft wall located in the attic above the D nurses' station had penetrations and a 6' x 4' portion of the was removed. These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 025	K 025 Continued On 6/29/11 Director of Environmental Service and Maintenance Assistant sealed penetrations in smoke barrier in attic above room 117; sealed smoke barrier to roof deck in attic above room 117; and sealed penetrations in draft wall in attic above D-Hall nurses station and installed door in 6'X4' opening. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? By 8/3/11 the Executive Director will have Preventative Maintenance plan for frequent attic penetration checks added to facility's online prompting system. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a weekly observation audit of attic for three months to ensure penetrations are sealed. Corrections will be made to doors as needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of weekly attic penetration audit will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011 8/3/2011 8/3/2011 8/3/2011
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observations, it was determined the	K 039		

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K 039	Continued From page 3 facility failed to maintain the corridors clear of equipment. The findings include: Observation 6/27/11 at 9:44 AM, revealed a lift was stored in the corridor next to room 163. Further observation at 10:18 AM, revealed the lift remained in the corridor for more then 30 minutes. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 039	K 039 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 6/27/11 lift was moved from hallway by CNA. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? By 7/21/11 the Executive Director/Director of Nursing will complete education with RNs/LPNs/CNAs to store lifts off hallway when not in use. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a weekly observation audit of corridors for three months to ensure lifts are properly stored. Corrections will be made as needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of weekly lift storage audit will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011 8/3/2011 8/3/2011 8/3/2011
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed the fire drill. The findings include: Observation during the fire drill on 6/27/11 at 12:54 PM, revealed staff member #1 failed to	K 050		

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K 050	Continued From page 4 clear and removal the residents from the room where the fire drill was occuring. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 050	K 050 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 7/12/11, the Executive Director completed in-service with staff member #1 on proper room evacuation procedures in case of fire.	8/3/2011
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system The findings include: Records review on 6/27/11 at 1:18 PM, revealed the facility to conduct the required quarterly sprinkler inspections during the 1st quarters of 2010 and 2011. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 062	B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? By 7/21/11, the Executive Director/Director of Enviromental Services/Maintenance Assistant will complete education of Dietary, Housekeeping, Laundry, Rehab, Nursing, Business Office, and Maintenance associates on proper procedures for evacuating patient room in case of fire. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a monthly observation audit for three months during monthly fire drills to ensure that rooms are properly evacuated. Education will be completed as needed.	8/3/2011 8/3/2011
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of monthly room evacuation audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011

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K 050	Continued From page 4 clear and removal the residents from the room where the fire drill was occuring. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 050	K 062 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 6/27/11, a sprinkler inspection was scheduled by the Executive Director. The sprinkler inspection was completed 7/1/11 by a sprinkler inspection company. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	8/3/2011
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system The findings include: Records review on 6/27/11 at 1:18 PM, revealed the facility to conduct the required quarterly sprinkler inspections during the 1st quarters of 2010 and 2011. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 062	By 7/21/11 the Executive Director will complete education with Maintenance Assistant and Director of Environmental Services on timely, quarterly completion of sprinkler inspection. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Executive Director will complete audit of facility's online preventative maintenance prompting and tracking system to ensure quarterly timely completion of sprinkler inspection. Corrections will be made if needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of quarterly sprinkler inspection audit will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011 8/3/2011 8/3/2011
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

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K 069	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to maintain and protect the cooking facilities. The findings include: 1. Observation of the kitchen's hood system on 12:20 PM, revealed the tilt skillet was not center over the fire extinguishing nozzles. 2. Observation of the kitchen's hood system on 6/27/11 at 12:21 PM, revealed a damaged filter. 3. Observation of the kitchen on 6/27/11 at 12:40 PM, revealed there were no instructions for manually operating the kitchen's hood fire-extinguishing system posted conspicuously in the kitchen. The instructions shall be reviewed periodically by the employees. 4. Interview with kitchen staff member #1 on 6/27/11 at 12:41 PM, revealed that staff member #1 did not know how to manually operate the kitchen's hood fire extinguishing system. Staff member #1 was not properly trained in how to extinguish an electrical or grease fire. 5. Record review on 6/27/11 at 1:20 PM, revealed the kitchen's 6 month hood cleaning was overdue (May 11). 6. Observation of the kitchen's hood exhaust fan on 6/27/11 at 1:25 PM, revealed the roof mounted exhaust fan was not secured to the exhaust duct assembly..	K 069	K 069 A. What corrective action(s) will be accomplished for those residents found to have been affected: 1) On 6/29/11 kitchen's tilt skillet was centered between rails over fire extinguishing nozzles by Maintenance Assistant and Director of Environmental Services. 2) Replacement filter for kitchen hood system was ordered 7/11/11 by Director of Environmental Services. 3) Instructions for manually operating the kitchen's hood fire-extinguishing system were posted by Dietary Service Manager on 7/14/11. Inservice for Dietary associates was given by Certified Dietary Manager on 7/14/11 regarding manually operating kitchen's hood fire-extinguishing system 4) On 7/14/11 staff member #1 was in-serviced by Dietary Service Manager on manual operation of kitchen's hood fire-extinguishing system and proper protocol for extinguishing electrical or grease fires. 5) Director of Environmental Services scheduled kitchen's hood cleaning for 7/19/11. 6) On 7/6/11 the Director of Environmental Services scheduled securement of exhaust fan to exhaust duct assembly on roof to be completed by 8/3/11. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? By 7/21/11 the Executive Director/Dietary Service Manager/Director of Environmental Services/Fixed Suppression System company will complete education with Dietary associates on correct placement of 1) tilt skillet, 2) proper reporting to supervisor of damaged equipment in kitchen, 3) placement of intrusions for manual operation of kitchen's hood fire-extinguisher system, 4) directions for manually operating kitchen's hood fire-extinguisher system and extinguishing process for electrical and grease fires. 5), 6) By 7/21/11, the Executive Director will educate Maintenance Assistant and Director of Environmental Services on hood cleaning schedule requirements and proper securement of exhaust fans for exhaust duct assembly.	8/3/2011 8/3/2011

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K 069	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to maintain and protect the cooking facilities. The findings include: 1. Observation of the kitchen's hood system on 12:20 PM, revealed the tilt skillet was not center over the fire extinguishing nozzles. 2. Observation of the kitchen's hood system on 6/27/11 at 12:21 PM, revealed a damaged filter. 3. Observation of the kitchen on 6/27/11 at 12:40 PM, revealed there were no instructions for manually operating the kitchen's hood fire-extinguishing system posted conspicuously in the kitchen. The instructions shall be reviewed periodically by the employees. 4. Interview with kitchen staff member #1 on 6/27/11 at 12:41 PM, revealed that staff member #1 did not know how to manually operate the kitchen's hood fire extinguishing system. Staff member #1 was not properly trained in how to extinguish an electrical or grease fire. 5. Record review on 6/27/11 at 1:20 PM, revealed the kitchen's 6 month hood cleaning was overdue (May 11). 6. Observation of the kitchen's hood exhaust fan on 6/27/11 at 1:25 PM, revealed the roof mounted exhaust fan was not secured to the exhaust duct assembly..	K 069	K 069 Continued C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance/Maintenance Assistant/Director of Environmental Services will conduct a monthly observation audit for three months to ensure 1) correct tilt skillet placement and 2) timely hood filter maintenance 3) correct placement of instructions for manual operation of kitchen's hood fire-extinguishing system 6) correct exhaust fan securement to exhaust duct assembly on roof. The Director of Maintenance/Maintenance Assistant/Director of Environmental Services/Certified Dietary Manager will conduct a monthly in-service with Dietary associates to ensure voiced understanding of 4) operation of kitchen's hood fire-extinguishing system, placement of instructions, and procedure for extinguishing electrical or grease fires. 5) Executive Director will conduct an observation audit of facility's online preventative maintenance tracking and prompting system to ensure hood cleaning is conducted timely. Corrections will be made as needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of audits for 1) tilt skillet, 2) hood filter maintenance, 3) instruction placement 4) kitchen's hood fire-extinguisher audit, procedure for electrical and grease fire, and 5) hood cleaning and 6) exhaust fan securement will be reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011 8/3/2011

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K 069	Continued From page 6 These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 069		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the oxygen storage room. The findings include: 1. Observation of the oxygen storage room on 6/27/11 at 10:55 AM, revealed 2 unsecured oxygen cylinders. 2. Observations of the oxygen storage room on 6/27/11 at 10:56 AM, revealed the electrical outlets and the lights on/off switch were not installed 5 feet above the floor. This finding was verified by the maintenance	K 076	K 076 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 6/27/11, unsecured oxygen cylinders were secured in cylynder crate by Director of Enviromental Services. 2) On 6/29/11, electrical outlets and light on/off switch were moved and reinstalled by electrical company to be five feet above the floor. B.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1) By 7/21/11, the Director of Nursing/Rehab Services Manager will complete education with RN/LPN/CNA/Rehab associates on secure storage of oxygen cyclynders. By 7/21/11, the Executive Director will complete education with Director of Enviromental Services and Maintenance Assistant on proper placement of electrical outlets and switches in oxygen storage rooms.	8/3/2011 8/3/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 6 These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 069		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the oxygen storage room. The findings include: 1. Observation of the oxygen storage room on 6/27/11 at 10:55 AM, revealed 2 unsecured oxygen cylinders. 2. Observations of the oxygen storage room on 6/27/11 at 10:56 AM, revealed the electrical outlets and the lights on/off switch were not installed 5 feet above the floor. This finding was verified by the maintenance	K 076	K 076 Continued C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance/Maintenance Assistant/Director of Enviromental Services will conduct a weekly observation audit for three months of the oxygen storage room to ensure proper securement and safety of oxygen cylinders. Corrections will be made as needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of oxygen safety storage audits will be reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011 8/3/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 076	Continued From page 7 supervisor and acknowledged by the administrator during the exit conference on 6/27/11	K 076	K 130 A. What corrective action(s) will be accomplished for those residents found to have been affected: 1) Director of Environmental Services and Maintenance Assistant sealed penetration in fire barrier located in the attic above room 146 by 7/8/11. 2) Director of Maintenance/Director of Environmental Services/Maintenance Assistant will conduct a Health Care Emergency Drill by 8/3/11.	8/3/11
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? By 7/21/11, the Executive Director will complete education with Director of Environmental Services and Maintenance Assistant on conducting semi-annual Emergency Preparedness Drills.	8/3/2011
	This STANDARD is not met as evidenced by: Penetrations and miscellaneous openings in fire barriers such as pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.		C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Executive Director will audit facility's preventative maintenance online tracking and prompting system for timely (semi-annual) completion of Emergency Preparedness Drills. Corrections will be made as needed.	8/3/2011
	Health Care Emergency Preparedness Drills: Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both.		D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of Emergency Preparedness audit will be reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011
	Based on observations and records review, it was determined the facility failed to maintain the fire barriers and failed to conduct the require Health Care Emergency Preparedness Drills. The findings include: 1. Observation on 6/27/11 at 9:48 AM, revealed penetrations in the fire barrier located in the attic above room 146.			

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	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 130	Continued From page 8 2. Record review on 6/27/11 at 1:23 PM, revealed the facility failed to conduct the required Health Care Emergency Preparedness Drills. These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 130	K 147 A. What corrective action(s) will be accomplished for those residents found to have been affected: 1) Electrical company applied protective cover to electrical circuit breaker box in attic above D-Hall nurses station by 7/8/11. 2) Electrical company applied protective cover to heating and cooling unit located in the attic above D-Hall nurses station by 7/8/11. 3) Maintenance Assistant removed extension chord in use in attic above D-Hall nurses station by 6/29/11. 4) Director of Environmental Services and Maintenance Assistant applied protective cover to back of dryer #3.	8/3/2011
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical equipment located in the attic. The findings include: 1. Observation on 6/27/11 at 10:07 AM, revealed the electrical circuit breaker box located in the attic above the D nurses' station was missing the protected cover. 2. Observation on 6/27/11 at 10:08 AM, revealed the heating and cooling unit located in the attic above the D nurses' station had exposed electricail wires with no protected cover. 3. Observation on 6/27/11 at 10:09 AM, revealed an extension cord was being used in the attic above the D nurses' station. 4. Observation of the laundry room on 6/27/11 at	K 147	B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? By 7/21/11 the Executive Director will complete education with Director of Environmental Services and Maintenance Assistant on use of covers for 1) breaker boxes, 2), 4) electrical wiring, and 3)proper use of extension chords.	8/3/2011
			C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance/Maintenance Assistant/Director of Environmental Services will conduct a monthly observation audit for three months of attic breaker boxes, attic heating and cooling units and linen dryers to ensure proper protective covers are in place. The Director of Maintenance/Maintenance Assistant/Director of Environmental Services will conduct a weekly observation audit for three months of extension chords used in attic. Corrections will be made as needed.	8/3/2011

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	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2011

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K 147	Continued From page 9 12:27 PM, revealed the back of dryer #3 had exposed electricail wires with no protected cover. These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.	K 147	K 147 Continued D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of oxygen storage audits will be reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.	8/3/2011